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Factors Associated With Intrauterine Device (IUD) Selection Among Postpartum Mothers : *A Cross-Sectional Study*

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ABSTRACT

Introduction *Unplanned pregnancy remains a major challenge for family planning programs in Indonesia. Although the intrauterine device (IUD) is highly effective, its use among postpartum women remains low. This study aimed to analyze factors associated with IUD selection among postpartum women at Sukaraja Community Health Center, Sukabumi Regency.*

Methods *This analytical observational study used a cross-sectional design and included 65 postpartum women selected through purposive sampling. Data were collected using a structured questionnaire and analyzed using the chi-square test and Fisher's exact test, with Odds Ratios (OR) and 95% Confidence Intervals (CI).*

Results *The results showed that knowledge (p = 0,000, OR = 16,250, 95% CI: 4,198-62,906), attitude (p = 0,000, OR = 25,227, 95% CI: 4,984-127,691), husband's support (p = 0,000, OR = 4,800, 95 CI: 1,441-15,993), and perceived side effect (p = 0,000, OR = 9,120, 95% CI: 2,601-31,974) were significantly associated with postpartum IUD selection. In contrast, health insurance participation (p = 0,415) and parity (p = 0,198) were not significantly associated. However, the extremely wide confidence intervals for knowledge and attitude indicate substantial statistical imprecision due to small sample size and sparse data constraints.*

Discussion and Conclusions *Postpartum IUD selection appeared to be more closely associated with cognitive and psychosocial factors, including knowledge, attitude, partner support, and concerns about side effects, than with financial access. Educational interventions should incorporate couple-centered counseling to address concerns regarding side effects during antenatal care.*

Keywords: *husband support, perceived side effects, postpartum contraception, IUD selection, maternal attitude.*

INTRODUCTION

Preventing unintended pregnancy and optimizing birth spacing are major goals of reproductive health interventions worldwide [1]. The World Health Organization (WHO) recognizes postpartum family planning (PPFP) as an important component of reproductive health care and recommends the intrauterine device (IUD) as a highly effective long-acting reversible contraceptive (LARC) suitable for immediate or early postpartum initiation[2][3]

Globally, IUD selection varies substantially across regions, with an estimated prevalence of 15.2% worldwide but approximately 6.7% in developing countries [1],[2]. In Indonesia, postpartum IUD selection remains low; national health surveys report that IUD selection account for only approximately 8.0%–8.33% of contraceptive users [2],[3]. Although the national contraceptive prevalence rate (CPR) target is 70% across all contraceptive methods, contraceptive use in Indonesia remains dominated by short-acting methods, particularly injectable and oral hormonal contraceptives [2],[3]. This gap indicates that uptake of the IUD as a long-acting contraceptive method remains suboptimal, despite its substantially higher effectiveness [1],[3].

The high use of short-acting contraceptive methods contributes directly to clinical risks and the socioeconomic burden of maternal health [4]. Short-acting methods are associated with higher rates of contraceptive failure and discontinuation because of missed reinjections or missed pills [5]. Unintended pregnancies and excessively short birth intervals increase the risk of serious obstetric complications, including anemia, postpartum hemorrhage, and low birth weight [3],[6]. Failure to prevent unintended pregnancy not only increases the financial burden on families but also places additional pressure on public health expenditures [6]. By preventing unintended pregnancy and promoting healthy birth spacing, long-acting methods such as the IUD may indirectly reduce preventable maternal health risks while optimizing household resource allocation[1],[6].

Although numerous empirical studies have examined factors associated with postpartum IUD selection, findings in the existing literature remain inconsistent [7],[8]. Some studies emphasize sociodemographic and economic factors, such as parity and participation in national health insurance (BPJS), as important determinants of contraceptive decision-making [7]. Conversely, other studies have reported no direct association between health insurance participation or parity and IUD selection, suggesting that insurance participation may not substantially determine contraceptive method choice [8],[9]. Emerging evidence instead indicates that cognitive and psychosocial variables—including knowledge, attitudes, concerns

about side effects, and husband's support—are significantly associated with contraceptive decision-making [9], [10], [11], [12].

Previous contraceptive research has generally examined financial barriers and psychosocial factors separately [13] [14]. However, it remains unclear whether access to subsidized health insurance through BPJS can adequately address concerns about side effects and insufficient partner support among postpartum women at the primary health-care level. Therefore, this study analyzed the associations of maternal knowledge, attitude, husband's support, perceived side effects, parity, and BPJS participation with postpartum IUD selection at Sukaraja Community Health Center, Sukabumi Regency. The findings are expected to provide empirical evidence to support the development of couple-centered postpartum family planning counseling that effectively addresses concerns about side effects in primary health-care settings.

METHODS

Study Design And Setting.

This analytical observational study used a cross-sectional design to examine the associations of maternal knowledge, attitude, husband's support, perceived side effects, parity, and BPJS participation with postpartum IUD selection at Sukaraja Community Health Center, Sukabumi Regency, from January to March 2025.

Participants

The target population comprised 79 postpartum women on days 1–42 after delivery who lived within the service area of Sukaraja Community Health Center. Participants were selected using purposive sampling based on predetermined inclusion and exclusion criteria.

The inclusion criteria were postpartum women aged 18–45 years who were able to communicate effectively in two directions and who lived with their husbands during the study period. This restriction was applied for methodological reasons to ensure the internal validity of the measurement of the "husband's support" variable as one of the key determinants. Including postpartum women who lived separately from their partners because of remote-work migration or domestic separation could increase the risk of nonresponse bias or information bias resulting from differences in the daily interaction context being assessed. Nevertheless, the authors acknowledge that this restriction represents a potential source of selection bias and may limit the external validity and generalizability of the findings to postpartum women who are unmarried, single parents, or geographically separated from their partners.

The exclusion criteria were severe postpartum complications, contraindications to IUD

insertion, or refusal to participate.

A total of 65 postpartum women met all eligibility criteria and participated in the study. The minimum sample size was calculated using a formula for estimating the difference between two independent proportions for an analytical study design (Lemeshow et al., 1990) [15],[16].

$$n = \frac{\left(Z_{1-\alpha/2}\sqrt{2\bar{P}(1-\bar{P})} + Z_{1-\beta}\sqrt{P_1(1-P_1)+P_2(1-P_2)}\right)^2}{(P_1-P_2)^2}$$

The parameters included a 95% confidence level (two-sided $Z_{1-\alpha/2}$ = 1,96), 80% statistical power ($Z_{1-\beta}$ = 0,84) and expected proportions of P_1= 0,60 and P_2 = 0,25 yielding an effect size of of 0,35[17]. Based on these calculations, the minimum required sample size was 58 participants[18]. To account for a potential 10% loss of data or nonresponse, the final sample size was increased to 65 participants.[19], [20].

Variables

The dependent variable was postpartum IUD selection, categorized as selected or not selected. The independent variables included maternal knowledge, attitude, husband's support, perceived side effects, parity, and National Health Insurance (BPJS) participation. Variable categories were established using sample-derived median cut-off values because the ordinal scores were not normally distributed, as verified by the Shapiro–Wilk test ($p < 0.05$). Attitude was categorized as positive (≥ median) or negative (< median). Husband's support was classified as supportive (≥ median) or unsupportive (< median). Perceived side effects were categorized as negative perception (≥ median) or positive perception (< median).

Instruments

Data were gathered using a structured questionnaire modified from the standard survey instrument of the National Population and Family Planning Board (BKKBN). The instrument was pretested on 20 postpartum women who were not included in the study sample at a neighboring primary health-care facility.

Construct validity was confirmed using Pearson's product-moment correlation (r), with an item considered valid when the calculated correlation coefficient exceeded > 0.444 (α = 0.05) . Internal consistency reliability was assessed using Cronbach's alpha ($\alpha > 0.70$): The Knowledge Scale: comprised 10 items (r_{range} = 0.482 - 0.765; Cronbach's α = 0.824); the Attitude Scale: comprised 8 items (r_{range} = 0.451- 0.712; Cronbach's α = 0.795); the Husband's Support Scale comprised 8 items (r_{range} = 0.510-0.801; Cronbach's α = 0.831); and Perceived Side Effects Scale comprised 8 items (r_{range} = 0.468-0.745; Cronbach's α = 0.812) [19], [20].

Procedures

Data were collected during home visits and routine postpartum health examinations at the community health center. Eligible women were informed about the study objectives, risks, and benefits. Written informed consent was obtained before data collection. Questionnaires were administered through face-to-face interviews conducted by trained research personnel to ensure data completeness.

Data Analysis

Data were analyzed using SPSS software. Univariate analysis was performed to calculate frequencies and percentages for categorical variables. Bivariate analysis used the chi-square test to assess associations between the independent variables and IUD selection. Fisher's exact test was applied when expected cell frequencies were less than 5 [16]. Statistical significance was defined as $p < 0.05$, Odds Ratios (OR) and 95% Confidence Intervals (CI) were calculated to estimate the strength and precision of the associations [16]

The study received ethical approval under registration number 086/e-KEPK/FIKES/VIII/2025. Sukaraja Community Health Center also granted permission for the study through permit number 400.7/1554/PKM/2025.

RESULT

The descriptive characteristics of the participants and the univariate distribution of the study variables are presented in Table 1. As shown in Table 1, postpartum IUD selection was dominated by non-selection: 48 participants (73.8%) did not select an IUD, whereas 17 (26.2%) selected a postpartum IUD.

Regarding cognitive and psychosocial factors, most respondents had inadequate knowledge of postpartum IUD, comprising 44 participants (67.7%). This distribution was accompanied by predominantly negative attitudes and limited partner support: 39 participants (60.0%) had negative attitudes, and 37 (56.9%) reported that their husbands were unsupportive. Furthermore, negative perceptions of clinical side effects were common, reported by 43 participants (66.2%). In contrast, health insurance coverage was relatively high in the study area, with 47 participants (72.3%) actively enrolled in BPJS. Regarding obstetric history, most postpartum women were multiparous or grand multiparous, accounting for 50 participants (76.9%).

Table 1 Univariate Analysis of Postpartum IUD Selection and Independent Variables (n = 65)

Variable	Frequency (f)	Percentage (%)
IUD Selection		
Selected	17	26,2
Not Selected	48	73,8
Knowledge		
Good	21	32,3
Not Good	44	67,7
Attitude		
Positif	26	40,0
Negatif	39	60,0
Husband's Support		
Supporti*ve*	28	43,1
Unsupportive	37	56,9
Perceived Side Effects		
Positive Perception	22	33,8
Negative Perception	43	66,2
BPJS Participation		
Active	47	72,3
Not Active	18	27,7
Paritas		
Primipara	15	23,1
Multipara/ Grandemultipara	50	76,9

Inferential analyses evaluating potential factors associated with postpartum IUD selection are summarized in Table 2. To account for contingency cells with small expected frequencies, particularly cells containing fewer than five participants, Fisher's exact test was used to obtain exact p-values together with the odds ratios (OR) and 95% confidence intervals (CI).

Table 2 Bivariate Analysis of Factors Associated with Postpartum IUD Selection (n = 65)

Variable	IUD Selection				Total		p value*	OR 95% CI
	Selected		No Selected					
	f	%	f	%	f	%		
Knowledge								
Good	13	61,9	8	38,1	21	100	0,000	16,25 (4,198-62,906)
No Good	4	9,1	40	90,9	44	100		
Attitude								
Positif	15	57,7	11	42,3	26	100	0,000	25,227 (4,984-127,691)
Negatif	2	5,1	37	94,9	39	100		
Husband's Support								

Supportive	12	42,9	16	57,1	28	100	0,000	4,8 (1,441-15,993)
Unsupportive	5	13,5	32	86,5	37	100		
Perceived Side effects								
Positive Perception	12	54,5	10	45,5	22	100	0,000	9,12 (2,601-31,974)
Negative Perception	5	11,6	38	88,4	43	100		
BPJS Participation								
Active	11	23,4	36	76,6	47	100	0,415	-
Not Active	6	33,3	12	66,7	18	100		
Paritas								
Primi	2	13,3	13	86,7	15	100	0,198	-
Multi/ Grande	15	30,0	35	70,0	50	100		

***p-value determined by Fisher's Exact Test due to small cell frequencies (f < 5); OR = Odds Ratio; CI = Confidence Interval*

The bivariate analysis presented in Table 2 showed statistically significant associations between maternal knowledge ($p < 0.001$), attitude ($p < 0.001$), husband's support ($p < 0.001$), perceived side effects ($p < 0.001$), and postpartum IUD selection. Women with good knowledge had substantially higher odds of selecting an IUD than women with not good knowledge (OR = 16.250, 95% CI: 4.198–62.906). Similarly, respondents with a positive attitude had higher odds of IUD selection than those with a negative attitude (OR = 25.227, 95% CI: 4.984–127.691). Women who reported supportive husbands also had higher odds of selecting an IUD (OR = 4.800, 95% CI: 1.441–15.993). Women with a positive perception of side effects, indicating lower concern about side effects, had higher odds of selecting an IUD (OR = 9.120, 95% CI: 2.601–31.974). In contrast, active BPJS participation ($p = 0.415$) and maternal parity ($p = 0.198$) were not significantly associated with postpartum IUD selection ($p > 0.05$).

DISCUSSION

This study analyzed factors associated with postpartum IUD selection in a primary health-care service area. Bivariate analysis showed that maternal knowledge, maternal attitude, husband's support, and perceived side effects were significantly associated with postpartum IUD selection (all $p < 0.001$). In contrast, active BPJS participation ($p = 0.415$) and maternal parity ($p = 0.198$) were not significantly associated with IUD selection. All interpretations in this discussion are based on bivariate analyses; multivariable regression was not performed

because of the limited sample size.

Knowledge is an important factor associated with contraceptive decision-making. Adequate understanding of the IUD may help women assess its characteristics, benefits, and relevant considerations before choosing a contraceptive method. Maternal attitude was also significantly associated with IUD selection, indicating that positive or negative evaluations of the method were related to the decision to IUD selection.

Conceptually, the association between attitude and IUD selection can be interpreted through the Theory of Planned Behavior (TPB). The TPB proposes that individual behavior is related to three main components: attitude toward the behavior, subjective norms, and perceived behavioral control[21]. In this study, the significant association between maternal attitude and IUD selection is consistent with the attitude-toward-the-behavior component of the TPB. However, the present study did not directly assess all TPB components; therefore, the TPB should be regarded as a conceptual framework for interpreting the observed association rather than as a formally tested theoretical model.

Maternal attitude reflects a positive or negative evaluation of IUD selection and may shape a woman's willingness to consider and select an IUD as a contraceptive method [22]. In this study, women with a positive attitude had substantially higher odds of selecting an IUD than women with a negative attitude, with a crude odds ratio (OR) of 25.227 (95% CI: 4.984–127.691; $p < 0.001$).

These findings are consistent with previous research indicating that contraceptive method selection is influenced by multiple factors, including knowledge, attitudes, perceptions of side effects, beliefs, perceived effectiveness, convenience, cost, previous contraceptive experience, partner approval, and social norms [22],[23]. Knowledge and attitude represent distinct but interrelated dimensions of contraceptive decision-making. Knowledge provides the informational basis for understanding the characteristics, benefits, and considerations associated with a contraceptive method, whereas attitude reflects how women evaluate that information based on their beliefs, perceptions, and preferences. The higher proportion of IUD selection among women with good knowledge and positive attitudes suggests that both dimensions are relevant to the contraceptive decision-making process.

Nevertheless, the magnitude of the OR from the bivariate analysis cannot establish causality or demonstrate that any single variable is the strongest independent factor because multivariable analysis was not performed. In addition, the cross-sectional design does not allow the temporal sequence between explanatory variables and IUD selection to be established. Therefore, it cannot be determined whether better knowledge and more positive attitudes

developed before women decided to select an IUD or emerged concurrently with the decision-making process.

The same pattern was observed for husband's support ($p < 0.001$; OR = 4.800) and perceived side effects ($p < 0.001$; OR = 9.120). These variables should not necessarily be viewed as isolated independent factors; rather, they are conceptually interconnected when interpreted within the Theory of Planned Behavior (TPB). Within the TPB framework, behavioral intention and health-related decisions are shaped by the interaction of subjective norms (social factors, including husband's support) and perceived behavioral control (which may be related to perceptions and concerns about side effects) [21], [23], [24], [25].

Consistent with the TPB framework, husband's support may function as part of the subjective norm and as an external reinforcing factor. Such support may validate a woman's perception of her ability to manage potential barriers and may reduce concerns about IUD-related side effects [11],[23],[25],[26],[27]. When husbands provide positive encouragement, women's psychological concerns about potential side effects, such as spotting or post-insertion cramping, may be reduced through shared emotional support [28]. Cooperative involvement by husbands may also strengthen women's perceived behavioral control, helping them feel more capable of managing potential side effects [29] . This interpretation is consistent with research suggesting that fear of side effects may be amplified when women face reproductive decisions without reliable partner support[28],[30] [31],[32].

Conversely, negative perceptions of side effects may arise from or be exacerbated by inadequate knowledge and limited husband's support, corresponding to an unfavorable subjective norm and lower perceived behavioral control [28],[33]. In settings where gender norms strongly influence reproductive decision-making, women's concerns about menstrual changes or discomfort during sexual intercourse may also be shaped by their husbands' perceptions or by commonly held myths[23],[25]. Therefore, providing accurate contraceptive information to both partners may help reduce concerns about IUD-related side effects [28].

The analysis showed no statistically significant association between BPJS participation ($p = 0.415$) or parity ($p = 0.198$) and postpartum IUD selection. Within the Theory of Planned Behavior, demographic characteristics such as parity and economic factors such as health insurance may be considered background factors. These factors do not necessarily determine behavior directly but may operate through more proximal psychosocial determinants, including personal attitudes, subjective norms, and perceived behavioral control. Thus, parity alone may not result in IUD or other long-acting contraceptive selection without adequate information and acceptance. Similarly, active BPJS membership may not determine the final contraceptive

choice when other factors, such as husband's support and perceptions of side effects, remain influential[34].[35].[36][4][23][25][37]

This shows that there has been a shift in perspective, from initially being a cost accessibility issue to psychological acceptance and personal/individual issues such as concerns about bleeding, fear during insertion, and patriarchal norms becoming more dominant determining factors in postpartum IUD selection.

The nonsignificant findings for these two variables may also have been affected by the limited sample size (n = 65) and the small number of IUD selection (n = 17), which reduced statistical power to detect small between-group differences. Therefore, these findings should be interpreted as an absence of statistically significant associations in the observed sample rather than as evidence that economic factors or reproductive history are irrelevant to postpartum family planning decisions in the broader population.

Practically, these observational findings support strengthening side-effect education and involving partners in antenatal or postpartum family planning counseling. However, this approach should be understood as a recommendation based on observed associations rather than as a clinical intervention whose effectiveness has been directly tested in a trial.

Interpretation of these findings should take into account several interrelated methodological limitations. The cross-sectional design prevents determination of temporal sequence or causality; therefore, the findings describe statistical associations only.

Regarding data collection, the use of self-reported measures may have introduced information bias and social desirability bias, whereby participants may have provided responses perceived as socially acceptable. In addition, selection bias cannot be excluded because the sampling frame was limited to one primary health-care service area; consequently, generalization to broader populations should be undertaken cautiously.

These methodological limitations were compounded by the relatively small sample size (n = 65), which resulted in sparse data and very low cell frequencies for some variable categories. This condition may have contributed to statistical instability, reflected in the very wide confidence intervals around several OR estimates. Finally, the small number of outcome events (17 women selecting an IUD) limited the feasibility of multivariable logistic regression, meaning that potential confounders such as income and educational level could not be statistically controlled.

CONCLUSIONS

Maternal knowledge, attitude, perceived side effects, and husband's support were significantly associated with postpartum IUD selection, whereas parity and BPJS participation were not significantly associated with IUD selection. Practical implications include strengthening education about expected side effects and involving partners in antenatal and postpartum family planning counseling. Prospective studies with larger samples and multivariable analyses are warranted to further evaluate these associations.

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